

72632-3

72632-3

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2015 JUL 8 PM 3:03

NO. 72632-3-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

CHRISTOPHER NELSON, a person,
REBECCA WIRTEL, a person,
and ALLI NELSON, a minor,

Appellants,

v.

GEICO GENERAL INSURANCE COMPANY, an insurance
company,

Respondent.

REPLY BRIEF OF APPELLANTS

Joel Hanson, WSBA #40814
JOEL B. HANSON, ATTORNEY AT LAW, PLLC
6100 – 219th St. SW, Suite #480
Mountlake Terrace, WA 98043
425-582-5636
joel@joelhansonlaw.com

Counsel for Appellants

ORIGINAL

TABLE OF CONTENTS

TABLE OF AUTHORITIES..... 1

ARGUMENT..... 1

 A. Respondent’s Brief Fails to Address Geico’s 13 Months of Inaction at the Start of the Claim..... 1

 B. Geico’s Failure to Make a Settlement Offer and Disclose the UIM Benefits Violated WAC 284-30-350(1).....2

 C. Geico Now Concedes it Had a Duty to Make a Settlement Offer.....4

 D. Appellants Were Harmed by Geico’s Delay.....6

 1. There is Evidence of Harm to Property.....6

 2. Appellants Have Not Abandoned their Argument that Attorney Fees Also Constitute Harm 12

 3. There is Evidence of Emotional Harm 12

 E. IFCA Does Apply to the 13-Month Delay in Payment and Failure to Disclose the Available Benefits..... 13

 F. Appellants’ IFCA Notice Was Sufficient..... 19

 G. Appellants Have Not Changed Their Position.....21

CONCLUSION..... 22

TABLE OF AUTHORITIES

CASES

Anderson v. State Farm Mut. Ins. Co., 101 Wn. App. 323, 330-33, 2 P.3d 1029 (2000)..... 2, 11

Banuelos v. TSA Washington, Inc., 134 Wn. App. 607, 614-15, 141 P.3d 652, 657 (2006)..... 9

Bronsink v. Allied Prop. & Cas. Ins. Co., 2010 WL 2342538, *2 (W.D. Wash. June 8, 2010) 17

<i>Cedar Grove Composting, Inc. v. Ironshore Specialty Ins. Co.</i> , No. C14-1443RAJ, 2015 WL 3473465, at *6 (W.D. Wash. June 2, 2015)	12
<i>Freeman v. State Farm Mut. Auto. Ins. Co.</i> , No. C11-761RAJ, 2012 WL 2891167, at *3 (W.D. Wash. July 16, 2012)	13
<i>Haley v. Allstate Ins. Co., Inc.</i> , 2010 WL 4052935 (W.D. Wash.) <i>on reconsideration in part</i> , 2010 WL 5224132, *7 (W.D. Wash. Dec. 14, 2010)	17
<i>Holmes v. Raffo</i> , 60 Wn.2d 421, 431, 374 P.2d 536 (1962)	10
<i>In re Welfare of B.R.S.H.</i> , 141 Wn. App. 39, 45, 169 P.3d 40 (2007)	5
<i>Langley v. GEICO Gen. Ins. Co.</i> , No. 1:14-CV-3069-SMJ, 2015 WL 778619, at *6 (E.D. Wash. Feb. 24, 2015)	16
<i>Little v. King</i> , 147 Wn. App. 883, 198 P.3d 525 (2008)	9
<i>Mason v. Mortgage Am., Inc.</i> , 114 Wn.2d 842, 854, 792 P.2d 142, 148 (1990)	7
<i>Rash v. Providence Health & Servs.</i> , 183 Wn. App. 612, 625, 334 P.3d 1154, 1161 (2014) <i>review denied</i> , 182 Wn. 2d 1028, 347 P.3d 459 (2015)	5
<i>Schneider v. Twin City Fire Ins. Co.</i> , 2011 WL 5592588 (W.D. Wash. Nov. 16, 2011.)	17
<i>State Farm Mut. Auto. Ins. Co. v. Amirpanahi</i> , 50 Wash. App. 869, n.1, 751 P.2d 329 (1988)	6
<i>Tavakoli v. Allstate Prop. & Cas. Ins. Co.</i> , 2012 WL 6677766 (W.D. Wash. Dec. 21, 2012)	16
<i>Walla Walla Cnty. Fire Prot. Dist. No. 5 v. Washington Auto Carriage, Inc.</i> , 50 Wash. App. 355, 358, n.1, 745 P.2d 1332, 1334 (1987)	6
<i>Woo v. Fireman's Fund Ins. Co.</i> , 161 Wn. 2d 43, 70, 164 P.3d 454, 467 (2007)	11, 12

STATUTES

RAP 2.5 5
RCW 19.52.010 9
RCW 48.30.015 15
WAC 284-30-330..... 4, 5, 6
WAC 284-30-350.....2, 3

ARGUMENT

A. Respondent's Brief Fails to Address Geico's 13 Months of Inaction at the Start of the Claim

Respondent's Brief barely acknowledges the facts that are central to Appellants' claims. Geico admits that Christopher Nelson notified Geico of the claim on August 10, 2011. Respondent's Brief at 4. Geico also admits that the first record of any discussion of settlement was on September 12, 2012.¹ Respondent's Brief at 5. Those dates are 13 months apart. Appellants testified that Geico did nothing during that time; Geico did not inform them of their UIM benefits and did not make any settlement offer. CP 206. Geico has still not offered any explanation as to what happened during those 13 months and why it did not disclose the benefits or make a settlement offer. If Geico cannot provide a reason for its lengthy delay, then *by definition* the delay was unreasonable.

¹ On September 12, 2012, an internal claim note showed that Geico employee Melanie Chron emailed Geico employee John Floyd and was "requesting [Floyd's] authority to settle the claim." CP 875. That statement confirms that, up until that date, Geico's employees still had not yet obtained authority from their supervisors to offer Appellants the full \$25,000 in policy limits. That same entry showed that Chron called Appellant and made the vague statement that he "is ready to settle". CP 874. It is unclear what that means and there is no evidence that Chron had ever discussed settlement with him prior to that date.

Appellants' allegations are undisputed. Geico has had every opportunity to impeach Appellants' testimony and to introduce conflicting testimony from its own employees. Geico took Appellants' depositions on May 22, 2014 (CP 620), which was a month after Geico received copies of Appellants' sworn declarations on April 17, 2014 (*See* CP 181 and 205). It is undisputed that while Geico paid money pursuant to the PIP coverage, Geico failed to inform Appellants of the \$25,000 available under the UIM coverage and failed to make a settlement offer. This failure lasted *at least* 13 months. Geico has not offered any justification for it.

B. Geico's Failure to Make a Settlement Offer and Disclose the UIM Benefits Violated WAC 284-30-350(1)

Geico argues that its 13-month failure to make a settlement offer and disclose the UIM benefits did not violate WAC 284-30-350(1). In *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 330-33, 2 P.3d 1029 (2000), this Court of Appeals found that an insurer's failure to disclose and offer UIM benefits for 10 months violated WAC 284-30-350(1) as a matter of law. Geico argues that this case is distinguishable from *Anderson* because Christopher

Nelson knew the term “uninsured motorist coverage”. Respondent’s Brief at 26. But his declaration shows that he did not know what benefits were available under that coverage. He did not understand the difference between his PIP coverage and his UIM coverage. Christopher Nelson was told to open a UIM claim, but nobody ever explained what that actually meant. He testified:

Upon contacting [the Washington State Crime Victims Compensation Fund] we were notified of our right to utilize our uninsured motorist insurance on both of our Geico car policies. Once we learned of this option, I immediately contacted Geico and initiated a claim.

At no time was I ever notified of any settlement offer or given any opportunity to accept a payment from Geico for our uninsured motorist coverage. It was my understanding that Alli was covered under the Personal Injury Protection (PIP), which paid medical expenses, and *Geico never told me that there were additional funds available under the policy*. Only after hiring an attorney, Joel Hanson, did we learn that there was additional money available under another part of the policy. I did not learn of any settlement offer until after we had retained Mr. Hanson.

CP 206 (emphasis added). Christopher Nelson knew he had coverage, but he did not know that benefits existed beyond the PIP coverage. Appellants were not sophisticated insurance customers.

Knowing that an insurance policy exists is not the same as knowing all of the benefits available under that policy. This is precisely why WAC 284-30-350(1) exists: to prevent insurers from concealing the availability of benefits due under a policy.

C. Geico Now Concedes it Had a Duty to Make a Settlement Offer

Geico concedes that “an insurer handling a UIM claim has an affirmative obligation to make a settlement offer.” Respondent’s Brief at 21, citing WAC 284-30-330(6). Geico does not explain why it made a contrary argument to the Superior Court. Instead, Geico says there was “admittedly some confusion” regarding this duty during oral argument. Respondent’s Brief at 21. Geico goes on to assert that WAC 284-30-330(6) “was never an issue in the case and the Court need not consider it.” Respondent’s Brief at 21-22. This is not accurate.

In fact, the Superior Court cited WAC 284-30-330(6) as a basis for its original order *denying* Geico’s motion to dismiss

Appellants' Consumer Protection Act (CPA) claims.² CP 943-44. Appellants also argued orally that there was a duty to make a settlement offer. VRP 37, lines 17-25. And Appellants cited WAC 284-30-330(6) in their briefing to the Superior Court. *See, e.g.*, CP 716-17. In light of the Superior Court's ruling that cited WAC 284-30-330(6), there can be no doubt that this issue was preserved for appeal.

The general rule is that, on appeal, a party may argue any issue that was raised at trial. RAP 2.5(a). "The purpose of this general rule is to give the trial court an opportunity to correct errors and avoid unnecessary rehearings." *Rash v. Providence Health & Servs.*, 183 Wn. App. 612, 625, 334 P.3d 1154, 1161 (2014) *review denied*, 182 Wn. 2d 1028, 347 P.3d 459 (2015). Even where an issue was not raised, the rule is permissive and does not automatically preclude the introduction of an issue at the appellate level. *In re Welfare of B.R.S.H.*, 141 Wn. App. 39, 45, 169 P.3d 40 (2007). As

² Appellants Opening Brief assigned error to the Superior Court's ruling that "there was no duty to make a settlement offer". This description of the Superior Court's multiple rulings was overly simplistic. Ultimately, the Superior Court's dismissal of Appellants' claims appears to have been based on a finding that there was no harm to Appellants, which is the second assignment of error.

long as the basic argument has been made at the trial court level, an issue is preserved even where a party failed to cite the proper legal authority. “There is no rule preventing an appellate court from considering case law not presented at the trial court level.” *Walla Walla Cnty. Fire Prot. Dist. No. 5 v. Washington Auto Carriage, Inc.*, 50 Wash. App. 355, 358, n.1, 745 P.2d 1332, 1334 (1987); *see also State Farm Mut. Auto. Ins. Co. v. Amirpanahi*, 50 Wash. App. 869, n.1, 751 P.2d 329 (1988) (“Although appellants did not argue *Sullivan* to the trial court, they did argue the basic reasoning ... This court can review these issues despite lack of citation to the crucial case law and treatises.”).

Here, Appellants cited WAC 284-30-330(6) to the Superior Court and the Superior Court cited it as a basis for rejecting one of Geico’s motions. That issue was undoubtedly preserved for appeal.

D. Appellants Were Harmed by Geico’s Delay

1. There is Evidence of Harm to Property

Geico argues that there was no harm to Appellants’ property. The *Anderson* decision found that the loss of interest on UIM funds and financial penalties both constituted harm to property. Geico

attempts to distinguish *Anderson* on the basis that the plaintiff in *Anderson* alleged loss of interest and financial penalties, whereas Appellants allege loss of interest and loss of the ability to afford medical treatment. But the only difference between this case and *Anderson* is that Appellants refrained from paying for medical treatment they could not afford.

For the purposes of the harm element of the CPA, all that matters is that Appellants suffered from a temporary loss of use of money. The loss of use *is itself* the harm, it does not matter whether additional harm occurred as a consequence of that loss of use. Washington law provides that loss of use of property, including money, is sufficient to establish harm under the CPA. *Mason v. Mortgage Am., Inc.*, 114 Wn.2d 842, 854, 792 P.2d 142, 148 (1990). It does not matter whether a precise dollar value can be calculated for that loss of use. *Id.*

Geico attempts to distinguish the other CPA cases cited by Appellants by arguing that the nature of the unfair practices were different. For example, Geico argues that *Banuelos* and *Sorrell* are distinguishable because in those cases the plaintiffs initially gave the

defendants the funds that were withheld, which is slightly different than what Geico did when it wrongfully withheld insurance funds that were owed to Appellants. But that distinction is relevant to the unfair practice element, not the element of harm. For the purpose of determining whether the element of harm has been met, it does not matter how the unfair practice element was met. What matters is whether a there was a loss of use of property.

Washington courts have consistently held that the loss of use of funds is harmful. For the purpose of determining harm, it does not matter why the funds are owed to the plaintiff. And there is no special exception for funds that are owed pursuant to an insurance contract. Insurance companies have a financial incentive to delay claim payments, but such delays are harmful to their customers.³ The *Anderson* decision established that a significant delay in payment of insurance proceeds is sufficient to meet the harm element.

Next, Geico argues that Appellants did not offer testimony

³ Insurance companies have an incentive to delay payments and withhold money they owe. This is because insurers keep all the money that is held in reserve for claims invested so that they can supplement their profit. This invested money is commonly referred to as the “float”.

that they would have deposited the insurance funds in an interest bearing bank account. But Washington law does not require plaintiffs to offer speculative testimony concerning how they would have invested money that has been withheld from them. For the purpose of determining the element of harm, all that matters is whether there was a loss of use of property. It does not matter how that property *might* have been used. For the purpose of determining damages, Washington law provides a set amount of 12-percent annual interest for any tort or breach arising from a contract that does not specify a different percentage. Appellants' Opening Brief cited *Banuelos v. TSA Washington, Inc.*, 134 Wn. App. 607, 614-15, 141 P.3d 652, 657 (2006) as authority that Appellants are entitled to the statutory 12-percent rate provided by Washington statute. Respondent's Brief offered no rebuttal to Appellants' argument on that point. Washington courts have applied the 12-percent rule to claims for benefits arising from UIM insurance contracts. *See, e.g., Little v. King*, 147 Wn. App. 883, 198 P.3d 525 (2008) (affirming an award of 12-percent interest for a delay in payment of UIM benefits).

Geico is essentially asking this Court to assume that Appellants would have stored the \$25,000 in UIM funds under a mattress once they received the funds from Geico, thereby avoiding the interest gains that are standard in any savings account. But this would be an absurd assumption to make. Indeed, the Superior Court judge that ultimately approved the \$25,000 settlement ordered Appellants to deposit the majority of the funds into a blocked savings account that cannot be accessed until Alli turns 18.⁴ Washington law requires that settlement funds owed to a minor must be placed in a “depository bank, trust company, or insured financial institution” under Washington law. SPR Rule 98.16W(i). Geico’s 13-month delay means there are 13 fewer months that Appellants’ funds will be collecting interest from that blocked savings account.

Even if Appellants could not possibly have obtained interest on their money, Christopher Nelson spent \$60 on medical expenses after the PIP coverage was exhausted. Geico criticized Christopher

⁴ The blocked savings account is interest bearing. Some of the funds were set aside to pay Alli’s medical expenses not covered by her insurance and some funds were set aside to invest in “Guaranteed Education Tuition” credits, a Washington state program to intended to help people to save for college tuition.

for not asking Geico to reimburse him for that money, but Geico has not offered any evidence that it would have generously reimbursed him for that payment after the PIP funds had already been exhausted.

While the \$60 spent on treatment might not seem significant, the more serious consequence of the delay in payment of the UIM funds was that it prevented Appellants from obtaining necessary treatment for Alli. Appellants testified that they would have paid for more medical treatment if they could have afforded it. The law should never condition recovery on financial ability. *Holmes v. Raffo*, 60 Wn.2d 421, 431, 374 P.2d 536 (1962) (vehicle owner deprived of use of vehicle may recover loss of use damages despite the fact that owner incurred no rental fees and could not afford to rent a replacement vehicle).

In conclusion, the element of harm was met when Appellants lost the use of their money and payment was delayed by 13 months. As a consequence of this loss of use, Appellants lost 13 months of interest on their funds, were unable to afford certain treatments, and paid \$60 towards those treatments they could not afford.

2. Appellants Have Not Abandoned their Argument that Attorney Fees Also Constitute Harm

Geico argues that Appellants have abandoned their argument concerning attorney fees. This is not quite accurate. There is a novel question concerning whether incurring contingent attorney fees may constitute harm in the same way that non-contingent attorney fees may constitute harm. Geico has not cited any authority in support of its argument that contingent attorney fees should be treated differently. This Court may address this issue and clarify the law in that regards. But Appellants are not emphasizing this issue because there is extensive case law supporting their argument that Geico's 13-month delay in disclosing, offering, and paying the \$25,000 is sufficient harm to meet the CPA.

3. There is Evidence of Emotional Harm

As discussed in Appellants' opening brief, this Court of Appeals has already held that a 10-month delay in processing a UIM claim may constitute emotional harm. *Anderson v. State Farm Mut. Ins. Co.*, 101 Wn. App. 323, 333, 2 P.3d 1029 (2000). These general damages are sufficient harm for both the tort of bad faith and a

violation of IFCA. Here, Appellants have testified that they were frustrated by Geico's delays and that they suffered as a result of being unable to pay Alli's medical bills. CP 201 at ¶ 13, CP 206-207. Emotional damages may be awarded based on a party's own testimony; Appellants need not present any expert testimony on this issue. *Woo v. Fireman's Fund Ins. Co.*, 161 Wn. 2d 43, 70, 164 P.3d 454, 467 (2007). In this case, the Superior Court explicitly ruled that there was evidence of emotional harm. CP 944. The order stated that "Plaintiffs are entitled to argue to the jury that (1) Geico failed to make a prompt settlement offer and (2) they suffered emotional damages as a result of this failure." CP 944. There was no reason for Appellants to submit a more detailed description of their emotional harm because the Superior Court had already ruled in their favor on this issue.

E. IFCA Does Apply to the 13-Month Delay in Payment and Failure to Disclose the Available Benefits

Geico argues it cannot be liable under IFCA because it did not explicitly deny coverage or benefits. However, courts have consistently found that IFCA liability extends beyond the explicit denial of coverage or benefits. "A refusal to pay a demand for

coverage reasonably promptly is an unreasonable denial of benefits, even if only temporary.” *Cedar Grove Composting, Inc. v. Ironshore Specialty Ins. Co.*, No. C14-1443RAJ, 2015 WL 3473465, at *6 (W.D. Wash. June 2, 2015). Similarly, Geico failed to disclose the existence of the UIM benefits to Appellants, and did not offer any money until at least 13 months after being notified of the claim. This was an unreasonable denial, even if was only temporary.

Insurers often argue that they can avoid IFCA liability if they ultimately pay some portion of a claim. Courts have rejected this argument. “For purposes of an insured's extracontractual claim, a failure to pay the amount the insured requests is a denial of coverage. Were it otherwise, an insurer could avoid extracontractual liability merely by conceding coverage, paying its insured one dollar, and refusing to pay any more.” *Freeman v. State Farm Mut. Auto. Ins. Co.*, No. C11-761RAJ, 2012 WL 2891167, at *3 (W.D. Wash. July 16, 2012). As another court explained:

[A]n insurer cannot escape IFCA simply by accepting a claim and paying or offering to pay an unreasonable amount. . . . Where the insurer pays or offers to pay a paltry amount that is not in line with the losses claimed, is not based on a reasoned evaluation of the facts (as known or,

in some cases, as would have been known had the insurer adequately investigated the claim), and would not compensate the insured for the loss at issue, the benefits promised in the policy are effectively denied.

Morella v. Safeco Ins. Co. of Illinois, No. C12-0672RSL, 2013 WL 1562032, at *3 (W.D. Wash. Apr. 12, 2013). Similarly:

Defendant initially contends, in its moving papers, that it cannot be liable for an IFCA violation because it did not deny “a claim,” it merely terminated Plaintiff’s benefits after a period of time. To call this a “selective” reading of the regulation would be an understatement. . . . The Court has no doubt that IFCA was intended to apply to this situation.

Schneider v. Twin City Fire Ins. Co., No. C11-04 MJP, 2011 WL 5592588, at *2 (W.D. Wash. Nov. 16, 2011)

While Geico did not explicitly deny a benefit, its failure to disclose an available UIM benefit was worse than an explicit denial of that benefit. When an insurer explicitly denies a benefit, it gives the insured an opportunity to evaluate the coverage decision and challenge it if the decision is incorrect. A failure to disclose the existence of a benefit robs the insured of any opportunity to pursue their rights and seek resolution of the dispute. An insurer should not be allowed to avoid IFCA liability simply by failing to disclose a

benefit, because that conduct is worse than an explicitly denial. Accordingly, for the purpose of IFCA, the failure to disclose a benefit is effectively a “denial”.

Seperately, even if this Court of Appeals were to disagree that the failure to disclose a benefit constitutes a denial, Geico also violated the IFCA when it violated WAC regulations such as WAC 284-30-330(6) and 350(1). The IFCA provided:

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including

expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";

(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";

(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";

(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";

(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"

RCW 48.30.015. Accordingly, under RCW 48.30.015(5), a violation of the WAC insurance regulations exposes the insurer to an award of up to treble damages under subsection (2) and an award of attorney

fees and litigations costs under subsection (3).

Some insurers have argued that, because subsection (1) does not mention subsection (5), plaintiffs may not bring actions solely on the basis of a WAC violation. Such an interpretation would render subsection (5) meaningless and nonsensical. How can an insurer be liable for attorney fees and treble damages for violating the WAC if a plaintiff may not actually bring such an action in court?

The legislative history of the IFCA confirms that it was intended to allow plaintiffs to sue for WAC violations. The Voter's Pamphlet for 2007 explained:

ESSB 5726 would authorize any first party claimant to bring a lawsuit in superior court against an insurer for unreasonably denying a claim for coverage or payment of benefits, **or violation of specified insurance commissioner unfair claims handling practices regulations**, to recover damages and reasonable attorney fees, and litigation costs.

2007 Voter's Pamphlet, page 14, Referendum 67. (Emphasis added.)⁵ The use of "or" clarifies that a lawsuit may be brought in superior court based on a violation of the claim handling regulations

⁵ A copy of pages 13-15 of the 2007 Voter's Pamphlet is enclosed as Appendix A. It can also be downloaded at:

http://www.sos.wa.gov/_assets/elections/Voters'%20Pamphlet%202007.pdf

even when there is not an unreasonable denial of coverage or benefits.

Several trial courts have found that the IFCA establishes an implied cause of action for violation of the WAC insurance regulations. The court in *Langley v. GEICO Gen. Ins. Co.*, No. 1:14-CV-3069-SMJ, 2015 WL 778619, at *6 (E.D. Wash. Feb. 24, 2015) held that “at a minimum, an independent implied cause of action exists under the IFCA for a first party claimant to bring a suit for a violation of the enumerated WAC provisions in RCW 48.30.015(5).” The *Langley* decision provided a detailed analysis of the statute and its legislative history. That decision also discussed the split between the federal courts in the Eastern District of Washington and the Western District of Washington on this issue. No appellate court has yet addressed this question.

F. Appellants’ IFCA Notice Was Sufficient

Respondent’s Brief argues that every issue in Appellants’ IFCA Notice was resolved. This is not accurate and this new argument was not litigated at the Superior Court level.

Appellants’ first IFCA Notice asserted that Geico had

violated the IFCA due to its “unreasonable [failure] to timely pay the full benefits due under their insurance policies.” CP 99. The IFCA Notice asserted that Geico still had not paid “all sums due under the policy.” CP 100. Appellants also asserted that Geico had violated the “Unfair Claims Settlement Practices”. CP 98. The “Cover Sheet” used by Appellants is the form provided by the Office of the Insurance Commissioner for any party wishing to file an IFCA Notice. Appellants’ central allegation in this matter is that Geico failed to timely pay their UIM benefits because Geico failed to disclose the existence of those benefits and failed to make any settlement offer or payment. Geico did not pay the policy limits of \$25,000 within 20 days of the IFCA Notice, nor did Geico pay Appellants that money prior to Appellants filing suit. The IFCA claim arising from Geico’s 13-month delay in paying the \$25,000 was preserved by Appellants’ first IFCA Notice and was not resolved.

Appellants also filed a second, more detailed IFCA Notice after Geico stated its belief that Appellants’ first IFCA Notice was not sufficiently broad. But that second Notice is not in the record

because Geico never formally challenged the sufficiency of Appellants' IFCA Notices. Respondent should not be allowed to raise an argument for the first time on appeal when the evidence on that issue was never presented to the Superior Court.

G. Appellants Have Not Changed Their Position

Geico argues that Appellants have changed their position. This argument is not supported by the facts. The Complaint asserted that "Geico failed to promptly investigate and pay Plaintiffs' insurance claims." CP 3 at line 22. Throughout the lawsuit, Appellants have asserted that Geico failed to disclose their UIM insurance benefits and delayed the payment of the claim. They asserted it in their response to Geico's first motion for summary judgment (CP 193-94), they asserted it in their own motion for partial summary judgment (CP 538-39), and asserted raised it a third time when they responded to Geico's second motion for summary judgment (CP 636).

Respondent's Brief does not argue that Appellants have made any inconsistent statements, nor does Respondent criticize the sufficiency of Appellants' Complaint or their discovery responses.

Geico simply wishes that that the entire case was resolved because Geico successfully argued that the policy limits should not be stacked. But the stacking issue was only one part of Appellants' case and Appellants are not limited to a single claim. Geico acted in bad faith and violated the insurance laws long before the stacking question arose. The stacking issue did not arise until two years after the loss, when Appellants turned to an attorney because Geico had failed to explain the UIM coverage and then opened a case in Superior Case without informing Appellants.

CONCLUSION

The Superior Court's dismissal of Appellant's claims for bad faith, violation of the CPA, and violation of the IFCA should be reversed and remanded for trial. Geico does not dispute that it waited at least 13 months to disclose the UIM benefits and make a settlement offer. Appellants were harmed by that 13-month delay in receiving their UIM benefits. This prevented them from obtaining interest on those funds and using those funds to pay for treatment they could not otherwise afford. Because these facts are undisputed, the Superior Court should be directed to enter a partial summary judgment finding

that Geico breached the duty of good faith, violated the CPA, and violated the IFCA as a matter of law. Appellants should also be awarded their attorney fees for the cost of this appeal.

RESPECTFULLY SUBMITTED this 31st day of July, 2015.

JOEL B. HANSON, ATTORNEY AT LAW,
PLLC

 /s/ Joel
Hanson
Joel B. Hanson, WSBA No. 40814
Counsel for Appellants

EXHIBIT A



REFERENDUM MEASURE 67

Passed by the Legislature and Ordered Referred by Petition

Official Ballot Title:

The legislature passed Engrossed Substitute Senate Bill 5726 (ESSB 5726) concerning insurance fair conduct related to claims for coverage or benefits and voters have filed a sufficient referendum petition on this bill.

This bill would make it unlawful for insurers to unreasonably deny certain coverage claims, and permit treble damages plus attorney fees for that and other violations. Some health insurance carriers would be exempt.

Should this bill be:

Approved [] Rejected []

Votes cast by the 2007 Legislature on final passage:

Senate: Yeas, 31; Nays, 18; Absent, 0; Excused, 0.

House: Yeas, 59; Nays, 38; Absent, 0; Excused, 1.

Note: The Official Ballot Title was written by the court. The Explanatory Statement was written by the Attorney General as required by law and revised by the court. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth fiscal analysis, visit www.ofm.wa.gov/initiatives. The complete text of Referendum Measure 67 begins on page 29.



Fiscal Impact Statement

Fiscal Impact Statement for Referendum 67

Referendum 67 is a referendum on ESSB 5726, a bill that would prohibit insurers from unreasonably denying certain insurance claims, permitting recovery up to triple damages plus attorney fees and litigation costs. This may increase frequency and amounts of insurance claims recovered by state and local government, the number of insurance-related suits filed in state courts, and increase state and local government insurance-premiums. Research offers no clear guidance for estimating the magnitude of these potential increases. Notice of insurance-related suits must be provided to the Office of the Insurance Commissioner prior to court filing, costing an estimated \$50,000 per year.

Assumptions for Fiscal Analysis of R-67

- There would likely be an increase in the number of cases filed in Superior Court related to the denial of insurance claims, but there is no data available to provide an accurate estimate of that fiscal impact. It is assumed that the impact to the operations of Washington courts would be greater than \$50,000 per year.
- Premiums for state and local governments that purchase auto, property, liability or other insurance may increase due to a potential increase in insurance companies' litigation costs and the amounts awarded to claimants.
- When the state or local government is a claimant, the referendum could increase the likelihood of recovering on the claim, and the amount recovered.
- Various studies have been conducted to determine how changes in law affecting insurance can affect costs for courts, insurance premiums, and claimant recovery. However, individual study results vary widely. Due to the conflicting research, there is no clear guidance for estimating the magnitude of the fiscal impact of potential increases in court costs, insurance premiums, or recovered claims.
- It is estimated that 300 notices per year of insurance-related lawsuits would be filed with the Office of the Insurance Commissioner, resulting in a minimum cost of less than \$50,000 per year increased cost to the agency.





REFERENDUM MEASURE 67

Explanatory Statement

The law as it presently exists:

The state insurance code prohibits any person engaged in the insurance business from engaging in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of their business. Some of these practices are set forth in state statute. The insurance commissioner has the authority to adopt rules defining unfair practices beyond those specified in statute. The commissioner has the authority to order any violators to cease and desist from their unfair practices, and to take action under the insurance code against violators for violation of statutes and regulations. Depending on the facts, the insurance commissioner could impose fines, seek injunctive relief, or take action to revoke an insurer's authority to conduct insurance business in this state.

Under existing law, an unfair denial of a claim against an insurance policy could give the claimant a legal action against the insurance company under one or more of several legal theories. These could include violation of the insurance code, violation of the consumer protection laws, personal injuries or property losses caused by the insurer's acts, or breach of contract. Depending on the facts and the legal basis for recovery, a claimant could recover money damages for the losses shown to have been caused by the defendant's behavior. Additional remedies might be available, depending on the legal basis for the claim.

Plaintiffs in Washington are not generally entitled to recover their attorney fees or litigation costs (except for small amounts set by state law) unless there is a specific statute, a contract provision, or recognized ground in case law providing for such recovery. Disputes over insurance coverage have been recognized in case law as permitting awards of attorney fees and costs. Likewise, plaintiffs in Washington are not generally entitled to collect punitive damages or damages in excess of their actual loss (such as double or triple the amount of actual loss), unless a statute or contract specifically provides for such payment.

The effect of the proposed measure, if approved:

This measure is a referral to the people of a bill (ESSB 5726) passed by the 2007 session of the legislature. The term "this bill" refers here to the bill as passed by the legislature. **A vote to "approve" this bill is a vote to approve ESSB 5726 as passed by the legislature. A vote to "reject" this bill is a vote to reject ESSB 5726 as passed by the legislature.**

ESSB 5726 would amend the laws concerning unfair or deceptive insurance practices by providing that an insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any "first party claimant." The term "first party claimant" is defined in the bill to mean an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

ESSB 5726 would authorize any first party claimant to bring a lawsuit in superior court against an insurer for unreasonably denying a claim for coverage or payment of benefits, or violation of specified insurance commissioner unfair claims handling practices regulations, to recover damages and reasonable attorney fees, and litigation costs. A successful plaintiff could recover the actual damages sustained, together with reasonable attorney fees and litigation costs as determined by the court. The court could also increase the total award of damages to an amount not exceeding three times the actual damages, if the court finds that an insurer has acted unreasonably in denying a claim or has violated certain rules adopted by the insurance commissioner. The new law would not limit a court's existing ability to provide other remedies available at law. The claimant would be required to give written notice to the insurer and to the insurance commissioner's office at least twenty days before filing the lawsuit.

ESSB 5726 would not apply to a health plan offered by a health carrier as defined in the insurance code. The term "health carrier" includes a disability insurer, a health care service contractor, or a health maintenance organization as those terms are defined in the insurance code. The term "health plan" means any policy, contract, or agreement offered by a health carrier to provide or pay for health care services, with certain exceptions set forth in the insurance code. These exceptions include, among other things, certain supplemental coverage, disability income, workers' compensation coverage, "accident only" coverage, "dental only" and "vision only" coverage, and plans which have a short-term limited purpose or duration. Because these types of coverage fall outside the definition of "health plan," ESSB 5726's provision would apply to these exceptions to "health plans."



Statement For Referendum Measure 67

APPROVE 67 – MAKE THE INSURANCE INDUSTRY TREAT ALL CONSUMERS FAIRLY.

Referendum 67 simply requires the Insurance Industry to be fair and pay legitimate claims in a reasonable and timely manner. Without R-67, there is no penalty when insurers delay or deny valid claims. R-67 would help make the Insurance Industry honor its commitments by making it against the law to unreasonably delay or deny legitimate claims.

APPROVE 67 – RIGHT NOW, THERE IS NO PENALTY FOR DELAYING OR DENYING YOUR VALID CLAIM.

R-67 encourages the Insurance Industry to treat legitimate insurance claims fairly. R-67 allows the court to assess penalties if an insurance company illegally delays or denies payment of a legitimate claim.

APPROVE 67 – YOU PAY FOR INSURANCE. THEY SHOULD KEEP THEIR PROMISES.

When you pay your premiums on time, the Insurance Industry is supposed to pay your legitimate claims. Unfortunately, the Insurance Industry sometimes puts profits ahead of people and intentionally delays or denies valid claims. R-67 makes the Insurance Industry keep its promises and pay legitimate claims on time. That is why the Insurance Industry is spending millions of dollars to defeat it.

APPROVE 67 – JOIN BIPARTISAN OFFICIALS AND CONSUMER GROUPS SUPPORTING FAIR TREATMENT BY THE INSURANCE INDUSTRY.

Insurance Commissioner Mike Kriedler, former Insurance Commissioners, seniors, workers, and consumer groups urge you to approve R-67. Supporters include the Puget Sound Alliance of Senior Citizens, former Republican Party State Chair Dale Foreman, the Labor Council, and the Fraternal Order of Police.

APPROVE 67 – R-67 SIMPLY MAKES SURE CLAIMS ARE HANDLED FAIRLY.

If the Insurance Industry honors its commitments, R-67 does not impose any new requirements – other than making sure all claims are handled fairly. R-67 would have an impact only on those bad apples that unreasonably delay or deny valid insurance claims.

For more information, visit www.approve67.org.

Rebuttal of Statement Against

Washington is one of only 5 states with no penalty when the Insurance Industry intentionally denies a valid claim. That is why the Insurance Industry is spending millions to defeat R67. Referendum 67 is only on the ballot because the Insurance Industry used its special-interest influence to block it from becoming law. Now you can vote to *approve* R67 to make fair treatment by the Insurance Industry the law. Approve R67 for Insurance Fairness.

Voters' Pamphlet Argument Prepared by:

STEVE KIRBY, Chair, House Insurance, Financial Services, Consumer Protection Committee; TOM CAMPBELL, Chair, House Environmental Health Committee; DIANE SOSNE, RN, President SEIU 1199; SKIP DREPS, Government Relations Director Northwest Paralyzed Veterans; KELLY FOX, President, Washington State Council of Firefighters; STEVE DZIELAK, Director, Alliance for Retired Americans.

Statement Against Referendum Measure 67

REJECT FRIVOLOUS LAWSUITS. REJECT HIGHER INSURANCE RATES. REJECT R-67.

As if there weren't enough frivolous lawsuits jacking up insurance rates, Washington's trial lawyers have invented yet another way to file more lawsuits to fatten their pocketbooks. They wrote and pushed a law through the Legislature that permits trial lawyers to threaten insurance companies with *triple damages* to force unreasonable settlements that will *increase insurance rates for all consumers*. The trial lawyers also included a provision that *guarantees payment of attorneys' fees*, sweetening the incentive to file frivolous lawsuits. There's no limit on the fees they can charge. What does this mean for consumers? You guessed it: *higher insurance rates*.

TRIAL LAWYERS WIN. CONSUMERS LOSE.

R-67 is a *windfall for trial lawyers* at the expense of consumers. Trial lawyers backed a similar law in California, but the resulting explosion of fraudulent claims and frivolous lawsuits caused auto insurance prices to increase 48% more than the national average (according to a national actuarial study) and *it was later repealed*.

CURRENT LAW PROTECTS CONSUMERS.

Insurance companies have a legal responsibility to treat people fairly, and *consumers can sue insurance companies under current law* if they believe their claim was handled improperly. The Insurance Commissioner can—and does—levy stiff fines, or even ban an insurance company from the state, if the company mistreats consumers.

R-67 IS BAD NEWS FOR CONSUMERS. REJECT R-67.

Not only does R-67 raise auto and homeowners insurance rates, it applies to small businesses and doctors as well. That means *higher medical bills and higher prices* for goods and services.

Laws should reduce frivolous lawsuits, not create more. Reject R-67!

See for yourself. Visit www.REJECT67.org.

Rebuttal of Statement For

Don't be fooled.

Trial lawyers didn't push this law through the legislature to protect *your* rights. They want this law because it gives them new opportunities to file *frivolous lawsuits* and collect *fat lawyers' fees*.

Trial lawyers don't care if frivolous lawsuits jack up our insurance rates. *Consumers, doctors and small businesses will pay more* so trial lawyers can file more lawsuits and collect larger fees.

Reject frivolous lawsuits and excessive lawyers' fees. Reject 67.

Voters' Pamphlet Argument Prepared by:

W. HUGH MALONEY, M.D., President, Washington State Medical Association; DON BRUNELL, President, Association of Washington Business; RICHARD BIGGS, President, Professional Insurance Agents of Washington; DANA CHILDERS, Executive Director, Liability Reform Coalition; TROY NICHOLS, Washington State Director, National Federation of Independent Business; BILL GARRITY, President, Washington Construction Industry Council.

CERTIFICATE OF SERVICE

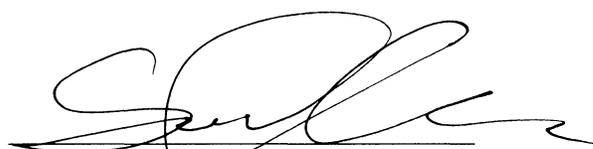
I certify that I caused to be served a copy of the foregoing APPELLANTS' REPLY BRIEF on the 31st day of July, 2015, to the following counsel of record at the following addresses:

Attorneys for Respondents

VIA LEGAL MESSENGER
Alfred Donohue
Sean W. Hornbrook
Wilson Smith Cochran Dickerson
901 Fifth Ave., Suite 1700
Seattle, WA 98161

VIA LEGAL MESSENGER
Court of Appeals, Division I
One Union Square
600 University Street
Seattle, WA

DATED at Mountlake Terrace, Washington this 31st day of July, 2015.


Sonia Chakalo